North Central Region EMS & Trauma Care System Plan

FY 2004 - 05

"Working together we do make a difference"

TABLE OF CONTENTS

INTRODUCTION

SYSTEM OPERATION COMPONENTS

North Central EMS and Trauma Care System Plan
FY 04-05

I. AUTHORITY

A. **RCW 70.168.015(7):** "Emergency medical services and trauma care system plan" means a state-wide plan that identifies state-wide emergency medical services and trauma care objectives and priorities and identifies equipment, facility, personnel, training and other needs required to create and maintain a state-wide emergency medical services and trauma care system. The plan also includes a plan of implementation that identifies the state, regional and local activities that will create, operate, maintain and enhance the system. The plan is formulated by incorporating the regional emergency medical services and trauma care plans required under this chapter..."

B. **EMTP Mission:** To establish, promote and maintain a system of effective emergency medical and trauma care services. Such a system provides timely and appropriate delivery of emergency medical treatment for people with acute illness and traumatic injury, and recognizes the changing methods and environment for providing optimal emergency care throughout the state of Washington.

C. **North Central Region EMS & Trauma Care Council Mission:** "Ensure the highest quality patient care possible through regional policy direction, injury prevention education, resource assistance and educational support, while furthering the goals of the Washington State EMS and Trauma Care System."

II. INTRODUCTION

A. Summary of Proposed Changes

In the North Central Region EMS & Trauma Care Plan for FY 04 –05, the Regional Council has identified two areas of change to minimum-maximum numbers of verified prehospital services:

1. It is requested that for Grant County, that the number of Amb-ALS be changed from three (3) to four (4). There is a need for increased service in Grant County Fire District 4 & 5.

There are no other recommended changes and no proposed higher than state standards.

B. Executive Summary

This plan represents the efforts of the North Central Regional EMS & Trauma Care Council, it's committees, and Local Councils, agencies, providers and staff to enhance the quality of care within the region, under the authority of the Department of Health, Office of Emergency Medical and Trauma Prevention, the Regional Council has designed a model trauma care system for the four counties, comprising the North Central Region of the State of Washington.

The North Central Region is located in the center of the State and consists of the four counties of Chelan, Douglas, Grant and Okanogan. The region has a population of 213,481 and covers 12,725 square miles. Within the region, there are 6,186 miles of county roads and approximately 51 miles of interstate highway. The region also includes four passes, Wauconda Pass and Loup Loup Pass In Okanogan County; and Stevens Pass and Blewitt Pass in Chelan County. The region is a desired vacation destination with its warm weather and over 13 state parks and many private summer vacation locations. It is primarily an agricultural region with apple production being one of the main commodities. This lends itself to a high influx of seasonal transient labor force.

Within the Region there are 11 designated trauma care facilities. The largest facility is the Level Two facility Central Washington Hospital located in Wenatchee. The hospitals, during the last year, have met numerous times to develop a Regional Bioterrorism Preparedness and Response Plan. These meetings were well attended and will continue but will broaden the areas of discussion. This venue will be beneficial to the hospitals and the region alike. As these relationships grow, more active interaction between the region, EMS agencies and hospitals will produce long term networking opportunities that will serve our citizens well.

The North Central Region EMS & Trauma Care Plan for 2004 – 05 identifies areas of need, issues to address and weaknesses to overcome. The overriding focus is to further develop and implement an efficient and effective trauma system, incorporated into the existing EMS prehospital system and healthcare facility network, designed to prevent trauma injuries, effectively treat and transport medical and trauma patients and rehabilitate trauma patients. The previous plan demonstrated how the existing system operates and identified needs that were known at the time. During the last biennium, the region has made great strides in the further development of collaborative efforts and will strive to enhance those relationships by meeting with various stakeholders to ensure cooperative and coordinated goals are established and accomplished. Through the work of our committees, the Region will continue to meet its role to review and recommend PCPs and, COPs; and, review and define response areas, while furthering the advancement of patient care in the region. Additionally the region will continue to make necessary recommendations for verified and designated trauma services and pursue system evaluation.

Accomplishments during the last planning cycle:

- Developed better communications between the agencies in the region
- Developed working relationships between hospital, pre-hospital and clinical disciplines
- Supported the Local Councils while increasing tasks assigned to them
- Provided consistent direction to all committees, council members, local councils
- Continued to identify and define response areas
- Improved dispatch to EMS agencies through training and support
- Established partnerships between the regional office and agencies/providers in the region.

Due to the changes in the plan format, this planning cycle has taken on a much more proactive approach. The Region has identified many areas where needs are evident. Examples of identified needs include the following:

- IPPE – (Spanish-Based)
- IPPE – Fall Prevention
- IPPE – Cardiac Emergency Awareness
- IPPE – Homeland Security Public Education
- Prehospital Communication – Single primary frequency
- Prehospital Communication – EMS NET for North Central Region
- Prehospital Communication – Multi-point communications system
- MPD Oversight – System Quality Assurance
- Prehospital Training – More SEIs throughout North Central Region
- Prehospital Training – Increased need for ALS training
- Prehospital EMS & Trauma Services – Lack of coordination of ambulance services
- Verified Services – Address the 3 R's – Right patient, Right agency, Right amount of time
- Designated Trauma Services – Encourage facilities to increase designation status
- Data Collection & Submission – Lack of objective data to evaluate effectiveness of system
- EMS & Trauma System Evaluation – Lack of communication to determine QA effectiveness

The vision of the Regional Council is that the areas identified in the FY 04-05 North Central Region EMS & Trauma Care System Plan as issues/needs/weaknesses will be addressed and through agency, provider and DOH involvement these areas can become strengths.

SYSTEM OPERATION COMPONENTS

III. INJURY PREVENTION & PUBLIC INFORMATION/EDUCATION

North Central Region Non-Fatal Injury Data - 1997-2001

Unintentional		**Total**
1st	Falls	3187
2nd	MVT (occupant, motorcycle, pedal cycle, pedestrian)	914
3rd	Poisoning	252
Suicide/Self Inflicted		
1st	Poisoning	309

North Central Region Fatal Injury Data - 1997-2001

Unintentional		**Total**
1st	MVT (occupant, motorcycle, pedal cycle, pedestrian)	270
2nd	Falls	74
3rd	Poisoning	67
Suicide/Self Inflicted		
1st	Firearm	88
2nd	Poisoning	22

A. Regional IPPE Programs

Injury Prevention and Public Education in the North Central Region is the work of prehospital agencies, healthcare agencies, the Council and countless others. The North Central Region has 43 agencies that provide emergency care in the area. Volunteers account for 75% of these agencies. These volunteers devote numerous hours to the promotion of safety and community activities in addition to their full time jobs. This leaves little time to be trained in injury prevention program presentations and give presentations during the workday. The hospitals within the region also provide many prevention activities, such as Trauma Nurses Talk Tough and Sober Roadway presentations. The North Central Region is making great progress in the area of injury prevention with the limited resources available by providing bicycle helmets for Bike Rodeos and Healthy Kids Days and through the many presentations given at schools throughout the region. An increase in funding would enhance quality program development, implementation of programs, and the ability to train professional presenters.

UNDERAGE IMPAIRED DRIVING

1.1 **Issue/Need/Weakness:** In a 7-year period from 1993 to 2000, 50 underage drinking drivers were killed in the four county region of Chelan, Okanogan, Douglas, and Grant. This compares to 288-killed statewide for the same period. Teens account for only 6.9% of all licensed drivers but they represent 15 % of all drivers involved in fatal crashes. This data was obtained from the Fatal Traffic Crashes in Washington State 1993-2000 (Washington Traffic Safety Commission FARS reporting system). There is no regional data available.

The region offers three impaired driving prevention programs, Sober Roadways, Trauma Nurses Talk Tough, and Think First, to the public in the four county area.

2.1
Goal 1: Serious injury and deaths from drinking and driving are reduced for persons under the legal drinking age.

Objective 1: By June 30, 2005, present at least 30 Sober Roadways/ Trauma Nurses Talk Tough/ or Think First programs reaching at least 800 high school students in North Central Region.

Strategy 1. Recruit qualified volunteer professional presenters for program presentations.

Strategy 2. Work with schools and speakers to develop a master schedule of program presentations.

Strategy 3. Conduct a pre and post written questionnaire of each program.

Strategy 4. Review region stats for death rates during the biennium and compare with pre-biennium stat.

Projected Costs: $5000.00

Barriers: Finding willing and qualified volunteers to present programs.

BICYCLE SAFETY

1.2 Issue/Need/Weakness: Bicycle Safety - From 1995 to 1999 as reported on the Washington State Department of Health, Center for Health Statistics, CHARS, 73 people were hospitalized in the region as the result the of bicycle collisions and another 3 died. In comparison 2,408 were hospitalized and 79 died in the state for this same period. The hospitalizations and deaths are low but still reflect a need to continue bicycle safety educational safety programs.

.

2.2

Goal 1: Reduce injuries and or death to children and adults through the use of bicycle helmets.

Objective 1: Distribute and properly fit at least 1000 helmets throughout the region during the biennium.

Strategy 1: Apply for grant funding to buy helmets.

Strategy 2: Distribute helmets for distribution throughout the region.

Objective 2: Support education on riding a bicycle properly through 8 bicycle rodeos throughout the region during the biennium.

***Strategy 1*:** Make available regional bicycle rodeo loaner kits to support community-organized rodeos.

Strategy 2: Apply for grant funding to purchase helmets for distribution.

Projected Cost: $10000.00

Barriers: Lack of trained community volunteers to implement quality bicycle rodeos and distribute and fit helmets.

FALL PREVENTION

1.3 Issue/Need/Weakness: The leading cause of death among citizens over the age of 65 is falls. From 1995-1999, as reported on the Washington State Department of Health, Center for Health Statistics, CHARS, in the state of Washington 1305 deaths was the direct result of falls among the elderly. This is followed by 53,049 nonfatal injury hospitalizations for the same period. The North Central Region data reflects 44 deaths and 2272 hospitalizations for the same period. This data reflects a need for education and prevention programs for the elderly.

2.3
Goal 1: Reduce the incident of injuries and/or death to the elderly as the result of falls.

Objective: Present at least 6 program presentations on fall prevention in the region during the biennium.

***Strategy 1*:** Contact regional health districts and senior centers offering fall prevention program presentations for the elderly to schedule presentations.

***Strategy 2*:** Use the Tread to Safety program format developed by the region for program presentations.

Projected Cost: $1000.00

Barriers: Developing an organized attendance of seniors to participate in program presentations.

SPANISH IPPE

1.4 Issue/Need/Weakness: It has also been identified that because of the considerable Hispanic population in the North Central Region, there is a need for injury prevention education for those citizens that only speak or read Spanish.

2.4
Goal 1: IPPE Programs/materials are available in Spanish

Objective 1: Obtain IPPE materials in Spanish to be used in biennium.

***Strategy 1*:** Work with local, regional and state Hispanic organizations to obtain injury prevention materials and educators that can begin to provide injury prevention education to the Hispanic community, specifically those that only speak or read Spanish.

Objective 2: Develop Spanish IPPE programs for presentation within the biennium.

Strategy 1: Have IPPE Committee develop IPPE programs around available Spanish IPPE material.

Objective 2: Determine venues for presenting Spanish IPPE programs

***Strategy 1*:** Contact Spanish focused civic organizations to enlist their help in scheduling presentations.

Strategy 2: Track the number of presentations given within the Hispanic population in an effort to determine the number of citizens reached with Spanish based injury prevention and public education.

Projected Cost: $5000.00

Barriers - None identified

CARDIAC EMERGENCY AWARENESS

1.5 Issue/Need/Weakness: Nationally, statewide and regionally, cardiac emergencies are the leading cause of medical intervention. Early recognition of a cardiac event is crucial to successful recovery.

2.5

Goal 1: The public can recognize and act on warning signs of cardiac emergencies.

Objective 1: Identify available or develop new educational programs and tools that can be used to educate the general public during the biennium.

***Strategy 1*:** Contact the AHA for available materials.

Objective 2: During the biennium partner with other healthcare organizations, such as hospitals, clinics and health districts to maximize the resources and increase the number of contacts.

Strategy 1: Determine locations for placement of materials or venues for programs.

Objective 3: Track the number of healthcare partners and the number of citizens exposed to the education will be an indicator of the potential impact that these programs will have.

Projected Cost: $1000.00

Barriers: Lack of human resources will be an area of concern and may make it difficult to accomplish.

ALL HAZARD PREPAREDNESS

1.6 Issue/Need/Weakness: Due to the tragic events of 9/11/2001 and the subsequent actions taken both federally and statewide, an identified need within the region is increasing public awareness of roles hospitals and EMS agencies have in educating and protecting/treating our citizens prior to and in the event of a bioterrorist attack.

2.6 Goal 1:

Citizens in the North Central Region are educated, prepared and comforted by the readiness of both hospitals and EMS agencies regarding disasters.

Objective 1: During the biennium, the region will be participating in numerous disaster preparedness drills. Prior to those events and during other emphasis weeks, (i.e. EMS Week), public service announcements, press releases and other media venues will be used to educate the citizens as to the levels of preparedness hospitals and EMS agencies are addressing.

Objective 2: Educate the citizens as to the potential hazards and how they should react to discovering a potential hazard and what resources Region will contribute to citizen understanding about hospitals and EMS interaction in disasters.

Strategy 1: In conjunction with various agencies, be sure informational and educational materials are available and in place for the purposes of informing and educating the public.

***Strategy 2*:** Utilizing both community web sites and the North Central Region's web site, the public will have access to information and internet links that will provide the education needed to react to real hazards.

Projected Cost: $5000.00

Barriers: None identified

Overall Projected Cost: $77000.00 includes the human resource element not included in the above projected costs.

IV. PREHOSPITAL

A. COMMUNICATIONS

1. Issues/Needs/Weaknesses

a. Public Access (e.g., E911, etc.)

Public access to EMS services in the North Central Region is good. Currently there are no areas that do not have 911 coverage. In addition, Chelan and Grant Counties have enhanced 911 coverage. As of late, the development of the On-Star system has added another way that the public can access the 911 systems of the region. Due to topographic issues, numerous areas throughout the region have communication gaps. These gaps include radio and cell phone limitations. This presents a possible risk for both the public at large and the EMS providers as in the event of an emergency incident, resources may be difficult to activate. As technological advances are made, these areas will become smaller and smaller.

b. Dispatch:

1. Training for Dispatch Personnel - Three of the four counties currently provide their dispatchers with some type of Emergency Medical Dispatch (EMD) training. The fourth county, Douglas, has a small dispatch center. The option for EMD training is currently available only outside the area, and would require an overnight stay of varying length. With a limited number of dispatchers, sending even one away would put a burden on the remaining dispatchers. The cost of overtime needed to cover during training, the training itself, and the travel expenses would be a financial burden for the agency.
2. Dispatch Prioritizing – All communications centers within the region have implemented dispatch prioritization as standard operating procedure.
3. Provisions for Bystander Care with Dispatch Assistance – Only Grant County's communication center, Multi-Agency Communication Center (MACC) has provisions for bystander care in their standard operating procedures. Upon the completion of the inter-regional communications center in Chelan and Douglas Counties, known as RiverCom, it too will provide for bystander care with dispatcher assistance.

4. PCPs – COPs development/change – The region's Prehospital Committee will be addressing the interaction between the region's communication centers and the Regional Council to provide input into daily operations. As appropriate, the committee will then determine which, if any, PCPs or COPs will need to be developed or changed.

c. Primary and Alternative Communications:

The primary means of communication in the North Central Region is by radio. All agencies in the North Central Region are dispatched, respond and operate on two primary dispatch frequencies. Agencies are notified by two methods: tone-voice paging and alphanumeric paging. A majority of agencies in Grant County and some in Chelan and Douglas Counties use both methods simultaneously to be notified of calls.

All agencies use radios, either mobiles or portables, to acknowledge the page, communicate with the emergency facilities (i.e. hospital emergency rooms), and communicate with their respective communication centers. A large number of agencies have cross-programmed their radios to facilitate communications between agencies. Two agencies in Grant County have established alternative methods for communication and dispatching in the event that MACC had technical problems or loses communication abilities.

There have been several discussions concerning frequency tasking and utilization between EMS and Fire service providers. Changes may be occurring in that area and the plan will be updated accordingly.

Moses Lake Fire Department, Central Grant Medic One, Ballard Ambulance Services and LifeLine Ambulance, Inc. are the only agencies in the North Central Region that receive calls for non-emergencies through an alternative provider.

The only agency that is not dispatched by MACC in Grant County is Central Grant Medic One.

d. System operation during single patient, multiple-patient, mass casualty and disaster incidents, identifying ambulance to ambulance, ambulance to dispatch, and ambulance to hospital communications systems

Single Patient incident – The call would be received at the dispatch center via 911 or enhanced 911; the call taker/dispatcher would receive the pertinent information, then tone out the agencies necessary to respond on the appropriate dispatch frequencies; the agency would acknowledge the page and all responding units would check enroute with the dispatch center; dispatch would provide updated information as they receive it. The arriving units would in turn check out on the scene with the dispatch center. After scene operations, the transporting ambulance would check enroute with dispatch to the hospital, the transporting ambulance would then make radio contact with the receiving hospital on the HEAR radio system for patient report; the transporting ambulance would check out at the receiving hospital with the dispatch center. All remaining units and the transport ambulance, when again available for calls, would notify the dispatcher of their status. Within the areas of East Wenatchee and Wenatchee, in Chelan and Douglas Counties, two agencies respond in the same area. They are currently responding on an every other call basis. This practice does not ensure that the closest ambulance is being dispatched. There are efforts underway to rectify this issue.

Within the Moses Lake area in Grant County, two agencies of equal provider certifications respond simultaneously which is not in the best interests of the citizens at large. Efforts to remedy this situation have met numerous obstacles; the Region's plan addresses this issue and offers a solution to it.

Multiple patient incident – These are handled in the same manner as a single patient incident with the primary exception being that more than one transport unit or multiple transport agencies would be notified depending on the scope of and nature of the incident. Mass Casualty incidents – Same as above, the MCI protocol would be instituted and all agencies would be dispatched. An intra-regional mass casualty response plan needs to be considered as an option.

Disaster incidents – Disaster incidents are handled in the same manner as an MCI, with the addition of statewide resources. Communications will be managed on the LERN frequency as is practiced in disaster drills.

e. Roles of other public and private agencies, e.g., police to fire to ambulance.

The roles of ancillary support agencies vary, but the communications between agencies is accomplished using the ICS (incident command system) thereby coordinating all communications through designated command posts and their respective frequencies. Interagency communications between support agencies and EMS agencies is accomplished via the LERN frequency, which is available to all emergency response agencies within the region.

f. Table A (see page 14)

2. Goals

EMS COMMUNICATIONS NETWORK

Goal 1: Communications centers work as a collaborative network in the North Central Region.

Objective 1: Work with regional communications centers to establish a common communications network by 2005.

***Strategy 1*:** Meet with the operation directors of all the regional communications centers to develop a common goal for the implementation of a region-wide EMS communications network.

Projected Cost: Unknown (Substantial)

Barriers: Lack of Funding for this project

HOSPITAL-TO-HOSPITAL COMMUNICATIONS

Goal 1: A multi-point communications system exists between all hospitals within the region

Objective 1: Seek funding and support from various state and federal sources to establish a reliable communication network between all hospitals in the region for the purposes of intra/inter-regional hospital communications by the end of the biennium.

Strategy 1: Meet with DOT representative as well as other state agencies representatives to determine common goals in providing interagency/interfacility communications.

Projected Cost: Unknown (Substantial)

EMD TRAINING

Goal 1: All communication centers within the region provide EMD training for all dispatch personnel.

Objective 1: Seek funding alternatives for providing EMD training on a regular basis for all communication center dispatch staff.

Strategy 1: Coordinate efforts with the Regional Homeland Security Coordinator to include EMD training in grant requests.

Projected Cost: $25,000.

Barriers: Lack of funding for this project

GPS TRANSPORT COORDINATION

Goal 1: The closest appropriate ambulance is always dispatched to EMS and trauma calls.

Objective 1: Provide GPS systems in ambulances of agencies that respond in the same geographic areas and provide the communication centers with appropriate hardware and software to monitor the system.

Strategy 1: Seek funding of GPS systems and encourage agencies to develop a system that ensures the closest ambulance responds.

Projected Cost: $50,000.

Barriers: Lack of funding for this project

TABLE A

EVALUATION OF COMMUNICATION SYSTEM PROVIDERS & DISPATCH ACTIVITIES

Communications Centers Survey List by County	1. Citizen Access	2. Consolidated	3. No. Employed	4. No. Not Trained	5. Kinds of Training & How Often	6. On-going Training	7. Kinds of Protocols	8. Med. Director involvement	9. Dispatch Prioritizing	10. Bystander Care	11. Pre-arrival Instructions	12. Quality Assurance
Grant County MACC	Yes	Yes	12	10	EMD	Yes		No	Yes	Yes	Yes	Yes
					2 YRS							
Douglas County	Yes	Yes	5	0	NONE	No		No	Yes	No	Yes	No
Okanogan County	Yes	Yes	12	9	EMD	No		No	Yes	No	Yes	No
					2 YRS							
Chelan Co. Sheriff	Yes	No	10	0	NONE	No		No	Yes	No	Yes	Yes
Chelan Police Dept	Yes	No	5	2	EMD	No		No	Yes	No	Yes	Yes
					2 YRS							
Wenatchee Police/Fire/EMS	Yes	Yes	13	13	EMD	No		No	Yes	No	Yes	Yes
					2 YRD							

B. Medical Direction of Prehospital Providers:

Currently all agencies in the Region have County MPD Protocols to use for medical direction off-line. Due to areas within the region with limited radio and cell phone coverage, EMS providers in the North Central Region rely on off-line medical direction in many cases. The MPD Protocols give very distinct direction and are vital to the delivery of emergency medical care in our rural areas. Where adequate communications allow, on-line medical direction is used to supplement the MPD Protocols. Neither the Local Councils nor Regional Council identified any Medical Direction of Prehospital Providers issues/needs/weaknesses. One MPD serves on the Prehospital Committee that reviews, revises and recommends PCPs. An MPD also serves as a member of the regional council and is actively involved.

1. Issue/Need/Weakness Statement 1: The region lacks MPD oversight of Regional QI Committee responsibilities to EMS system.

2. Goal 1: The Regional QI Committee and the MPDs interact effectively to assure EMS & trauma issues are addressed.

> **Objective 1:** Provide the Regional QI Committee direction and areas of concern that will be tracked and addressed as needed within the first year of the biennium.
>
> ***Strategy 1:*** Develop a working relationship between the MPDs and the Regional QI Committee. Encourage the MPDs to attend the Regional QI Committee meetings which are held quarterly.

Projected Cost: $45,000.

Barrier: MPDs unwillingness to attend and funds to pay MPDs.

C. Prehospital EMS and Trauma Services

a. Current EMS/TC Personnel Resources

North Central Region Personnel County by County

County	FR	EMT	IV	AW	IV/AW	ILS	ILS/AW	PM	TOTALS
Chelan	21	213	36	0	1	0	0	28	299
Douglas	16	77	5	0	0	0	0	0	98
Grant	51	163	9	0	0	11	16	31	281
Okanogan	23	123	10	0	1	1	8	5	171
Grand Totals	**111**	**576**	**60**	**0**	**2**	**12**	**24**	**64**	**849**

b. Prehospital Training: Recently, a survey was sent to many of the licensed agencies within the North Central Region EMS and Trauma Care Council. These and other needs follow:

SENIOR EMT INSTRUCTORS

1. Issue/Need/Weakness Statement: There is a shortage of Senior EMT instructors and many have stated that they are seriously considering not maintaining their instructor status due to the increasing requirement demands on them to maintain their certification. It is difficult to find SEI's to put on First Responder and EMT classes in the rural areas. Losing even one of these current instructors would be

detrimental to providing necessary initial training to these volunteer agencies already lacking in acceptable numbers of qualified volunteers.

2. Goal 1: Senior EMT Instructors meet the need for initial training and CME needs throughout the region.

Objective 1: Provide broader representation on the Regional Training and Education Committee by January 2004, to make sure that all concerns are voiced at the regional level and communicated to the state committee.

Objective 2: Work with the existing SEIs in the area to identify concerns and address them through regional education planning in 2004.

Strategy 1: Meetings between the Training & Education Committee and the region's SEIs will be held to discuss areas of concern and ideas to be forwarded to the DOH OEMTP for consideration.

Objective 3: By the end of 2003, the Region's Training & Education Committee will develop a plan and timeline for beginning a dialogue with the SEIs to gain a consensus on how to increase the number of qualified instructors available in the region.

***Strategy 1*:** The Training & Education committee will meet, and with input from the MPDs, will develop the plan.

Projected Cost: Unknown

Barriers: Lack of willing participants

COORDINATION OF TRAINING OPPORTUNITIES

1. Issue/Need/Weakness Statement: There is a concern that there is a lack of coordination/cooperation between agencies in planning and providing varied types and amounts of training (both OTEP and otherwise). This weakness is only related to specific areas IN THE REGION.. In the Wenatchee and Chelan areas, several agencies have coordinated, and others are currently implementing efforts to provide multi-agency OTEP classes.

2. Goal 1: All EMS agencies that are in close proximity to other EMS agencies provide multi-agency training and OTEP.

Objective 1: The Regional Council and the Training & Education Committee will work to develop a coordinated continuing education plan that will review the current training plan and propose changes by the end of the biennium.

Strategy 1: The Training & Education Committee will meet to discuss ways to coordinate training sessions that will maximize the efficiency of the classes provided by the Region.

Projected Cost: Minimal

Barriers: None identified

ALS CME

1. Issue/Need/Weakness Statement: An identified need is more ALS continuing medical education in our region. It is difficult for paramedics working in our area to obtain enough continuing education hours for recertification. Most of the paramedics have to travel several hundred miles around the state to obtain enough hours to qualify for recertification; this greatly increases the cost for agencies.

2. Goal 1: ALS CME is readily available and adequately funded.

Objective 1: During FY 04-05, seek funding for more ALS training in our area.

Objective 2: During FY 04, the Training & Education Committee will develop a plan to provide ALS training for the agencies within the Region.

Strategy 1: The Training & Education Committee, with input from the MPDs, will meet to determine the needs of the region and to develop a plan to find funding for ALS training.

Projected Cost: $50,000.

Barriers: Lack of funding for this project

INITIAL TRAINING

1. Issue/Need/Weakness Statement: First Responder and EMT-Basic initial training courses are regularly presented throughout the region, but those courses are not coordinated with the region's office.

2. Goal 1: All initial FR & EMT-B courses will be coordinated through the regional office so that any interested parties will have an opportunity to attend if space is available.

Objective 1: For fiscal year 2004 – 05 develop a plan that will ensure that all interested individuals and agencies will know when & where classes will be held.

Strategy 1: The Training & Education Committee will determine a course of action for gathering information about when & where First Responder and EMT-Basic initial classes are being held and develop a mechanism for disseminating that information to regional office, agencies and individuals.

Projected Cost: $5000.

Barriers: Ineffective communication between course coordinators and region office.

ALL HAZARDS PREPAREDNESS

1. Issue/Need/Weakness Statement: A regional all hazards preparedness and response plan and necessary training for agencies in the North Central Region is a recognized need. Due to the recent emphasis on this issue the Regional Council has determined that this type of plan and training is currently not provided and is very vital to our region and state.

2. Goal 1: The region has an all hazards preparedness and response plan and training program in place.

> **Objective 1:** For fiscal year 2004 – 05, develop an all hazards preparedness and response plan and training program that will demonstrate a process for ensuring all EMS agencies in the region have the opportunity to send their personnel to classes focused on all hazards preparedness and response. This plan will ensure that all interested individuals and agencies will know when & where classes will be held.
>
> ***Strategy 1:*** The Training & Education Committee will take action to develop an all hazards plan and training program, and will determine a course of action for establishing a process for notifying all providers of the content of the all hazards preparedness and response and training program.

Projected Cost: $25,000.

Barriers: Lack of funding for this project

CLINICAL CME

1. Issue/Need/Weakness Statement: Currently, limited clinical facilities are available within the region for personnel to receive training or maintain required skills for their level of certification. Several agencies are pursuing or have contracts with facilities outside of the North Central Region for skill maintenance.

2. Goal 1: The Healthcare Facilities assist agencies and personnel with maintaining clinical skills.

> **Objective 1:** During the 2004 – 05 fiscal year the Healthcare Facilities Committee will meet with hospital representatives to determine if relationships can be built to assist the EMS agencies within the region in receiving/maintaining required skills.
>
> ***Strategy 1:*** The Healthcare Facilities Committee will attempt to address the concerns and issues that may be an obstacle in finalizing relationships with the facilities for ongoing training and skill maintenance and work with hospital representatives to develop a plan for such.

Projected Cost: $5,000.

Barriers: Lack of cooperation with the healthcare facilities and lack of funding

COMMUNICATION OF INFORMATION

1. Issue/Need/Weakness Statement: Currently, other than a bi-monthly newsletter the North Central Region has no method for announcement of training to agencies in the county. A mechanism is needed to enhance inter-agency communications.

2. Goal 1: The region's web page is an effective tool for intra-regional and inter-agency communication.

Objective 1: During fiscal year 2004 develop a process that will give agencies web space on the Region's web page for placing their training calendar or similar information to be accessed by agencies and individuals.

Strategy 1: The Region's office staff will work with a web developer to expand the Region's web site to allow for agencies to add, change or delete information specific to their activities.

Projected Cost: $2500.

Barriers: Lack of funding for this project

CLINICAL EVALUATION

1. Issue/Need/Weakness Statement: Combi-tube evaluator training was identified as a weakness in the 2000-2001plan. To-date, no courses have been offered to provide this type of evaluator training in Grant County. Documentation does not indicate that this weakness has ever been resolved.

2. Goal 1: An adequate number of Combi-tube evaluators are available to meet training needs.

Objective 1: Assess the need for and provide, if determined necessary, combi-tube evaluator training for individuals requesting the type of training as needed.

Strategy 1: Prior to the beginning of 2004, assess the need and develop a plan for training of combi-tube evaluators.

Strategy 2: The Training & Education Committee will make an assessment of the need for combi-tube evaluator training and develop a plan to provide that training. In the process, the committee will determine how to fund this type of training.

Projected Cost: $7500.

Barriers: Lack of funding for this project

ONGOING TRAINING & EVALUATION PROGRAM

1. Issue/Need/Weakness Statement: Agencies that are conducting their own OTEP lack any funding or support for those programs. Training and Education is an on-going area of both strength and weakness for all agencies in North Central Region. The majority of agencies in the North Central Region EMS system are primarily volunteer staffed and operated. With a large number of volunteers, it is at times difficult to provide training to all personnel in a consistent manner.

Currently, eight agencies use their own OTEP program. Grant County Fire District 8, in addition to utilizing Inland Empire Training, contracts with Yakima County EMS for OTEP training. All other agencies in the North Central Region currently rely on the Inland Empire EMS Training Council from Spokane, Washington to conduct BLS OTEP for providers. The OTEP training has helped significantly with standardizing the consistent scheduling, delivery and quality of training provided throughout the county.

OTEP training is conducted through a contract between North Central Region and Inland Empire EMS Training Council. Funding for this type of training is essential for the North Central Region, as a majority of agencies in the region are primarily volunteer personnel and do not have the resources to develop and manage their own programs.

2. Goal 1: Agency managed OTEP is available as a continuing education option in the region.

Objective 1: During FY 04, determine the feasibility of the Region financially assisting agencies to provide their own OTEP training; if feasible, recommend a plan for regional council consideration.

Strategy 1: The Training & Education Committee will be tasked with determining if available funds currently used for training are sufficient to provide assistance for agencies that conduct their own OTEP training and developing recommendations to the regional council.

Projected Cost: Unknown

Barriers: Lack of funding for this project

Goal 2: Provide, as feasible, existing and new teleconferencing opportunities for OTEP classes.

Objective 1: Determine existing locations and possible future locations for teleconferencing of OTEP classes by the end of the biennium.

Strategy 1: Contact the hospitals in the region that currently have teleconferencing capabilities to determine the willingness and availability of their facilities for OTEP classes.
Strategy 2: Determine potential locations for teleconferencing "links" to provide OTEP classes.

Projected Cost: $50,000 upfront and $50, 000 annually thereafter

Barriers: Lack of funding for this project.

c. Prioritizing and conducting prehospital training

The North Central Region's Training and Education Committee meets at a least 6 times per year to determine the priority of training and the region contracts with the Inland Empire EMS Training Council for its regional OTEP. The Training and Education Committee has oversight of the contract.

d. Additional public safety personnel

Throughout the North Central Region, we are very fortunate to have a good working relationship with a large contingency of Public Safety entities that provide an invaluable service to the EMS system in the areas of: safety, scene command, extrication, search and rescue, water rescue, confined space rescue, BLS first response, fire suppression, Clandestine Drug Lab Removal, scene assistance, mass evacuation, emergency housing and additional man power as needed.

The following are the Public Safety entities that assist our EMS system in the North Central Region:

Washington State Patrol	County Sheriff Departments
Local city police and fire departments	US Forest Service
US Park Service	County Search and Rescue
Military Air Rescue	County Fire Departments
Local Transit Authorities	

Without the assistance of these vital entities, our EMS system would be hard pressed to have the total coverage we now enjoy. On countless occasions, these Public Safety personnel have contributed and assisted the EMS response.

D. Verified Aid and Ambulance Service
1a.

- **Current Geo-political prehospital response areas by County-by Fire District or City-by urban, suburban, rural, wilderness categories**
- **Current Distribution of Verified Services by type and level of service-by agency**
- **Maps and descriptions of Service Areas**
- **Need for unmet services or changes in services**

CHELAN COUNTY

Geo-political	Current Distribution of Trauma Verified Services	Verified Services Response Areas for Major Trauma Incidents	Needs: Unmet service needs or changes in service needs for Trauma Verified Services
Chelan County Fire Dist. #1 (Rural)	BLS Aid - Chelan Co. FD #1 ALS Transport - Ballard Ambulance Services, LifeLine Ambulance Inc.	Chelan County Fire Dist. #1 proper – Maps and/or description available at Regional Office	
Chelan County Fire Dist #3 (Rural)	BLS Aid – Chelan Co. FD #3 BLS Transport - Not Currently Provided ALS Transport – Cascade Ambulance Service	Chelan County Fire Dist. #3 proper – Maps and/or description available at Regional Office	
Chelan County Fire Dist #4 (Rural/Wilderness)	BLS Aid – Chelan Co. FD #4 BLS Transport - Not Currently Provided ALS Transport – Cascade Ambulance Service	Chelan County Fire Dist. #4 proper – Maps and/or description available at Regional Office	Within Chelan Co. Fire Dist. #4, it has been identified that there is a need for a Verified BLS Transport Service.
Chelan County Fire Dist. #6 (Rural/Wilderness)	BLS Aid - Dryden Fire Department (Peshastin FD Licensed Only) BLS Transport - Cashmere Fire Depart. ALS Transport – Cascade Ambulance Service, Ballard Ambulance Services, LifeLine Ambulance Inc.	Chelan County Fire Dist. #6 proper – Maps and/or description available at Regional Office	The Peshastin Fire Department response area is in need of a Verified BLS Aid Service. Within Chelan Co. Fire Dist. #6, it has been identified that there is a need for a BLS Verified Transport Service.
Chelan County Fire Dist #8 (Rural/Wilderness)	BLS Transport - Chelan Co. FD #8 ALS Transport - Ballard Ambulance Service, Lake Chelan EMS	Chelan County Fire Dist. #8 proper – Maps and/or description available at Regional Office	
Chelan Co PHD #2 (Rural/Wilderness)	ALS Transport – Lake Chelan EMS	Chelan County PHD #2 proper – Maps and/or description available at Regional Office	

City of Cashmere (Rural)	BLS Transport - Cashmere Fire Department ALS Transport - Ballard Ambulance, LifeLine Ambulance	City limits of Cashmere proper. Map and/or description available at Regional Council Office.	
City of Wenatchee (Suburban)	BLS Aid - Wenatchee Fire Department ALS Transport - Ballard Ambulance & LifeLine Ambulance	City limits of Wenatchee proper. Maps and/or description available at Regional Council Office	
National Park Service-Stehekin (Wilderness)	BLS Aid – ALS Transport – Northwest MedStar, Lake Chelan EMS	Town of Stehekin and surrounding wilderness area. Maps and/or description available at Regional Council Office.	

D. Verified Aid and Ambulance Service
1a.

- **Current Geo-political prehospital response areas by County-by Fire District or City-by urban, suburban, rural, wilderness categories**
- **Current Distribution of Verified Services by type and level of service-by agency**
- **Maps and descriptions of Service Areas**
- **Need for unmet services or changes in services**

DOUGLAS COUNTY

Geo-political	Current Distribution of Trauma Verified Services	Verified Services Response Areas for Major Trauma Incidents	Needs: Unmet service needs or changes in service needs for Trauma Verified Services
Douglas County Fire Dist. #1 (Suburban/Rural)	BLS Transport – Waterville Ambulance Service, Mansfield Volunteer Fire Department ALS Transport -Ballard Ambulance Service, LifeLine Ambulance Inc.	Douglas County Fire Dist. # 1 proper – Map and description available at Regional Council Office.	
Douglas County Fire Dist. #2 (Suburban/Rural)	BLS Aid – Douglas Co. FD #2 ALS Transport - Ballard Ambulance Service, LifeLine Ambulance Inc.	Douglas County Fire Dist. # 2 proper – Map and description available at Regional Council Office.	
Douglas County Fire Dist. #3 (Suburban/Rural)	BLS Aid - Not Currently Provided (#1) BLS Transport - Bridgeport Ambulance Service, Mansfield Volunteer Fire Department, Grand Coulee Fire Department	Douglas County Fire Dist. # 3 proper – Map and description available at Regional Council Office.	Within the boundaries of Douglas County FD #3,there is a need for Verified BLS Aid Service due to the sometimes-lengthy response by the nearest ambulance.
Douglas County Fire Dist #4 (Rural)	BLS Aid - Not Currently BLS Transport - BLS Transport - Waterville Ambulance Service, Mansfield Volunteer Fire Department ALS Transport - Ballard Ambulance Service, LifeLine Ambulance Inc., Lake Chelan EMS	Douglas County Fire Dist. # 4 proper – Map and description available at Regional Council Office.	

Douglas County Fire Dist. #5 (Suburban/Rural)	BLS Transport - Mansfield Volunteer Fire Department, Bridgeport Ambulance Service ALS Transport - Lake Chelan EMS	Douglas County Fire Dist. # 5 proper – Map and description available at Regional Council Office.	
Douglas County Fire Dist. #6 (Suburban/Rural)	BLS Aid - Not Currently Provided (#1) BLS Transport - Brewster Ambulance Service	Douglas County Fire Dist. # 6 proper – Map and description available at Regional Council Office.	Within the boundaries of Douglas County FD #6, there is a need for a Verified BLS Aid Service due to the sometimes-lengthy response by the nearest ambulance.
Douglas County Fire Dist. #7 (Suburban/Rural)	BLS Aid - Not Currently Provided (#1) BLS Transport - Bridgeport Ambulance Service, Mansfield Volunteer Fire Department	Douglas County Fire Dist. # 7 proper – Map and description available at Regional Council Office.	Within the boundaries of Douglas County FD #7,there is a need for a Verified BLS Aid Service due to the sometimes-lengthy response by the nearest ambulance.
City of Bridgeport (Rural)	BLS Transport – Bridgeport Ambulance Service	City Limits of Bridgeport proper. Map and description available at Regional Council Office.	

D. Verified Aid and Ambulance Service
1a.

- **Current Geo-political prehospital response areas by County-by Fire District or City -by urban, suburban, rural, wilderness categories**
- **Current Distribution of Verified Services by type and level of service-by agency**
- **Maps and descriptions of Service Areas**
- **Need for unmet services or changes in services**

GRANT COUNTY

Geo-political	Current Distribution of Trauma Verified Services	Verified Services Response Areas for Major Trauma Incidents	Needs: Unmet service needs or changes in service needs for Trauma Verified Services
Grant County Fire Dist #3 (Rural)	BLS Aid - Grant Co. FD #3 BLS Transport - Quincy Valley Ambulance & Grant Co. FD # 10 ALS Transport - Quincy Valley Amb. & Ephrata Amb. Service (Parts of Fire Dist. #3.)	Grant County Fire Dist. #3 proper – Map and description available at Regional Council Office.	
Grant County Fire Dist #4 (Rural)	BLS Aid – Grant Co. FD #4 ILS Transport - Central Grant Medic One ALS Transport- Grant County Fire Dist. #5 (Licensed only)	Grant County Fire Dist. #4 proper – Map and description available at Regional Council Office.	Within the boundaries of Grant County Fire Dist. #4, there is an identified need for a Verified ALS Transport Service due to the increased population and proximity of ALS transport services to those populated areas. Verified ILS Transport Service would not be required if an additional Verified ALS Transport Service was available.
Grant County Fire Dist #5 (Suburban/Rural)	BLS Aid - Not Currently Provided BLS Transport - Grant Co. FD #10 ILS Transport - Central Grant Medic One ALS Transport - Grant County Fire Dist. #5 (licensed only)	Grant County Fire Dist. #5 proper – Map and description available at Regional Council Office.	Within the boundaries of Grant County Fire Dist. #5, there is an identified need for a Verified ALS Transport Service due to the increased population and proximity of ALS transport services to those populated areas. Verified ILS Transport Service would not be required if an additional Verified ALS Transport Service was available.

Grant County Fire Dist #6 (Rural)	BLS Transport - Grant Co. FD #6, Coulee City Fire Depart, Grand Coulee FD ILS Transport - Not Currently Provided	Grant County Fire Dist. #6 proper – Map and description available at Regional Council Office.	There is an identified need for a Verified ILS Transport Services in the response areas of either Coulee City or Grant County FD #6, due to the distance and length of response of the nearest ILS or higher service.
Grant County Fire Dist #7 (Rural)	BLS Aid - Grant Co. FD #7 BLS Transport - Coulee City Fire Depart. & Grant Co. FD #6 ILS Transport - Central Grant Medic One ALS Transport - Ephrata Ambulance Service	Grant County Fire Dist. #7 proper – Map and description available at Regional Council Office.	Verified ILS Transport Service would not be required if an additional Verified ALS Transport Service was available.
Grant County Fire Dist #8 (Rural/Wilderness)	BLS Transport - Grant Co. FD #8 ILS Transport - Not Currently Provided	Grant County Fire Dist. #8 proper – Map and description available at Regional Council Office.	There is an identified need for a Verified ILS Transport Services in the response areas of Grant County FD #8 due to the distance and length of response of the nearest ILS or higher service.
Grant County Fire Dist #10 (Rural/Wilderness)	BLS Transport - Grant Co. FD #10 & Grant Co. FD #8 ILS Transport - Not Currently Provided	Grant County Fire Dist. #10 proper– Map and description available at Regional Council Office.	There is an identified need for a Verified ILS Transport Services in the response areas of Grant County FD #10, due to the distance and length of response of the nearest ILS or higher service.
Grant County Fire Dist #11 (Rural/Wilderness)	BLS Transport - Grant Co. FD #10 ILS Transport -Not Currently Provided	Grant County Fire Dist. #11 proper– Map and description available at Regional Council Office.	There is an identified need for a Verified ILS Transport Services in the response areas of Grant County FD #11, due to the distance and length of response of the nearest ILS or higher service.
Grant County FPD #12 (Rural/Wilderness)	BLS Aid - Grant Co. #12 (Licensed only) BLS Transport - Partial Coverage by Coulee City Amb & Grant Co. FD #6 ILS Transport - Central Grant Medic One ALS Transport - Ephrata Ambulance Service	Grant County Fire Dist. #12 proper – Map and description available at Regional Council Office.	Within the boundaries of Grant County FD #12, there is an identified need for a Verified BLS Transport Service, due to the desire for more rapid ambulance response. Verified ILS Transport Service would not be required if an additional Verified ALS Transport Service was available.

Grant County Fire Dist #13 (Rural/Wilderness)	BLS Aid - Grant Co. Fire Dist. #13 ALS Transport - Ephrata Ambulance Service	Grant County Fire Dist. #13 proper– Map and description available at Regional Council Office.	
Grant Count Fire Dist. # 14 (Rural/Wilderness)	BLS Aid -Not Currently Provided BLS Transport – Grand Coulee Fire Department	Grant County Fire Dist. #14 proper– Map and description available at Regional Council Office.	
Grant County Fire Dist #15 (Rural/Wilderness)	BLS Aid - Not Currently Provided BLS Transport - Partial Coverage by Grant Co. FD #10 ILS Transport – Central Grant Medic One ALS Transport - Ephrata Ambulance Service	Grant County Fire Dist. #15 proper– Map and description available at Regional Council Office.	ILS Transport would not be required if an additional Verified ALS Transport Service was available.
City of Coulee City (Rural)	BLS Transport – Coulee City Fire Department ILS Transport – Not Currently Provided	City limits of Coulee City proper – Map and description available at Regional Council Office.	There is an identified need for Verified ILS Transport Service in the response areas of Coulee Fire Department due to the distance and length of response of the nearest ILS or higher service.
City of Ephrata (Rural)	BLS Aid - Ephrata Fire Department ALS Transport - Ephrata Ambulance Service	City limits of Ephrata proper – Map and description available at Regional Council Office.	
City of Grand Coulee (Rural)	BLS Transport - Grand Coulee Fire Department ILS Transport - Not Currently Provided	City limits of Grand Coulee proper – Map and description available at Regional Council Office.	There is an identified need for ILS transport services in the response areas of Grand Coulee Fire Department, due to the distance and length of response of the nearest ILS or higher service.
City of Moses Lake (Suburban)	ILS Transport - Central Grant Medic One ALS Transport - Moses Lake Fire Department	City of Moses Lake proper – Map and description available at Regional Council Office.	ILS Transport would not be required if an additional verified ALS Transport Service was available.
Port of Moses Lake (Rural)	BLS Aid - Port of Moses Lake Fire Department ILS Transport - Central Grant Medic One ALS Transport - Grant County Fire Dist. #5 (Licensed only)	Port district boundaries. Grant County International Airport & Surrounding Industries – Map and description available at Regional Council Office.	Within the boundaries of the Port of Moses Lake, there is an identified need for a Verified ALS Transport Service. Verified ILS Transport would not be required if an additional Verified ALS Transport Service was available.

D. Verified Aid and Ambulance Service
1a.

- **Current Geo-political prehospital response areas by County-by Fire District or City-by urban, suburban, rural, wilderness categories**
- **Current Distribution of Verified Services by type and level of service-by agency**
- **Maps and descriptions of Service Areas**
- **Need for unmet services or changes in services**

OKANOGAN COUNTY

Geo-political	Current Distribution of Trauma Verified Services	Verified Services Response Areas for Major Trauma Incidents	Needs: Unmet service needs or changes in service needs for Trauma Verified Services
Okanogan County Fire Dist #1 (Rural)	BLS Transport - Oroville Ambulance Service	Okanogan County Fire Dist. #1 proper. Map and/or description available at Regional Council Office.	
Okanogan County Fire Dist #2 (Rural)	BLS Transport - Coulee Dam Volunteer FD	Okanogan County Fire Dist. #1 proper. Map and/or description available at Regional Council Office.	
Okanogan County Fire Dist #3 (Rural)	BLS Aid - Not Currently Provided BLS Transport - Okanogan Co. FD #5 ALS Transport - LifeLine Ambulance, Inc	Okanogan County Fire Dist. #3 proper. Map and/or description available at Regional Council Office.	Within the boundaries of Okanogan County FD #3, there is a need for a Verified BLS Aid Service due to the sometimes-lengthy response by the nearest ambulance.
Okanogan County Fire Dist #4 (Rural)	BLS Aid - Not Currently Provided BLS Transport - LifeLine Ambulance Inc.	Okanogan County Fire Dist. #4 proper. Map and/or description available at Regional Council Office.	Within the boundaries of Okanogan County FD #4, there is a need for a Verified BLS Aid Service due to the sometimes-lengthy response by the nearest ambulance.
Okanogan County Fire Dist #5 (Rural)	BLS Aid - Not Currently Provided BLS Transport - Okanogan Co. FD#5	Okanogan County Fire Dist. #5 proper. Map and/or description available at Regional Council Office.	
Okanogan County Fire Dist #6 (Rural)	BLS Aid - Twisp Fire & Rescue ALS Transport - Aero Methow Rescue Service	Okanogan County Fire Dist. #6 proper. Map and/or description available at Regional Council Office.	

Okanogan County Fire Dist #7 (Rural)	BLS Aid - Not Currently Provided ALS Transport - LifeLine Ambulance, Inc	Okanogan County Fire Dist. #7 proper. Map and/or description available at Regional Council Office.	
Okanogan County Fire Dist #8 (Rural)	BLS Aid - Malott FD BLS Transport - Okanogan FD #5, ALS Transport - LifeLine Ambulance, Inc.	Okanogan County Fire Dist. #8 proper. Map and/or description available at Regional Council Office.	
Okanogan County Fire Dist #9 (Rural)	BLS Aid - Conconully Volunteer Fire Department ALS Transport - LifeLine Ambulance, Inc.	Okanogan County Fire Dist. #9 proper. Map and/or description available at Regional Council Office.	
Okanogan County Fire Dist #10 (Rural)	BLS Aid – Malott FD BLS Transport - LifeLine Ambulance, Inc.	Okanogan County Fire Dist. #10 proper. Map and/or description available at Regional Council Office.	
Okanogan County Fire Dist #11 (Rural)	BLS Aid - Not Currently Provided BLS Transport - Oroville Ambulance Service, LifeLine Ambulance, Inc.	Okanogan County Fire Dist. #11 proper. Map and/or description available at Regional Council Office.	Within the boundaries of Okanogan County FD #11, there is a need for a Verified BLS Aid Service due to the sometimes-lengthy response by the nearest ambulance.
Okanogan County Fire Dist #12 (Rural)	BLS Aid - Not Currently Provided ALS Transport - LifeLine Ambulance, Inc.	Okanogan County Fire Dist. #12 proper. Map and/or description available at Regional Council Office.	Within the boundaries of Okanogan County FD #12, there is a need for a Verified BLS Aid Service due to the sometimes-lengthy response by the nearest ambulance.
Colville Tribal Reservation (Rural/Wilderness)	BLS Transport - Colville Tribal Emergency Services, Bridgeport Ambulance, Coulee Dam Fire Dept., Okanogan FD #5	Colville Tribal Reservation – Map and/or description available at Regional Council Office.	

1. b. Distribution of Services is based RCW70.168.100(1)(h) and WAC 246-976-960(1)(b)(i) and state criteria. County recommendations are under #1 above by county. Grant County justification for change in minimum/maximum services is Appendix II.

Trauma Verified Transport Services

1. Issue/Need/Weakness Statement: There is an identified need for a trauma verified transport service in the greater Moses Lake area due to the increased population and proximity of trauma verified ALS transport services to those populated areas.

2. Goal 1: A trauma verified ALS transport service responds to EMS and trauma calls from locations near rural areas where the increased population warrants it.

> **Objective 1:** Within the biennium seek an increase of one trauma verified ALS transport service in the greater Moses Lake area to provide more rapid response in areas where geography, topography, population and response times make it appropriate for an additional verified ALS transport service.
>
> ***Strategy 1:*** Through appropriate channels, request from the Department of Health, Office of Emergency Medical and Trauma System an increase of one in the number of trauma verified ALS transport services.

Projected Cost: Unknown

Barriers: None Identified

4.

Table B

North Central Region **Chelan County** **December 2002**

Min/Max Numbers for Trauma-Verified Prehospital Services

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	4	6	5	4	6
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb - BLS	2	4	2	2	4
Amb - ILS	0	0	0	0	0
Amb - ALS	4	4	4	4	4

Table B

North Central Region **Douglas County** **December 2002**

Min/Max Numbers for Trauma-Verified Prehospital Services

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	1	5	1	1	5
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb - BLS	3	4	3	3	4
Amb - ILS	0	1	0	0	1
Amb - ALS	0	0	0*	0*	0*

*Within the southern portion of Douglas County in East Wenatchee and surrounding rural area, three ALS verified agencies respond to provide service. The agencies are; Ballard Ambulance Services, LifeLine Ambulance, Inc. and Lake Chelan EMS Services.

Table B

North Central Region **Grant County** **December 2002**

Min/Max Numbers for Trauma-Verified Prehospital Services

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	4	11	4	4	11
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb - BLS	4	8	5	4	8
Amb - ILS	0	5	1	1	5
Amb - ALS	1	3	3	1	4*

Table B

North Central Region **Okanogan County** **December 2002**

Min/Max Numbers for Trauma-Verified Prehospital Services

Services	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
Aid - BLS	1	9	3	1	9
Aid - ILS	0	0	0	0	0
Aid - ALS	0	0	0	0	0
Amb - BLS	3	6	4	3	6
Amb - ILS	0	2	0	0	2
Amb - ALS	1	2	2	1	2

E. **Patient Care Procedures (PCPs) and County Operating Procedures (COPs): Current Status: PCP & COPs are Appendix II**

Issue/Need/Weakness Statement: Progress on updating, revising and developing new PCPs and COPs has been slow in coming. The North Central Region's PCP committee has struggled with determining a direction to proceed.

Goal 1: PCPs and COPs meet the current needs of the Regional and County EMS and Trauma Systems of the North Central Region.

Objective 1: During FY 04 - 05, the North Central Region's PCP committee will review the PCPs and recommend updates or additional PCPs.

Strategy 1: The North Central Region's PCP committee will meet regularly to establish a timetable for developing, revising and drafting recommendations for the North Central Region's PCPs.

Strategy 2: The North Central Region's PCP committee will meet to review the PCPs other regions have in place and determine if there is a need to develop new PCPs for the North Central Region. They will draft recommendations for the Regional Council to consider.

Strategy 3: The North Central Region's PCP committee will meet to draft recommendations for updating existing PCPs.

Objective 2: At the Local Council meetings in the North Central Region, the Local Councils will be encouraged to form a local council committee to review COPs in place throughout the state to determine if there is any applicability to their respective counties.

Strategy 1: The Region's Office staff will provide access to COPs from other counties.

Projected Cost: Minimal

Barriers: None identified

F. Multi county or county/inter-regional Prehospital Care:

Issue/Need/Weakness

No issues/needs/weaknesses were identified in this area. The Regional Council will monitor this area to ensure that coordination and cooperation between counties and inter-regional regarding prehospital care is addressed as necessary.

Goal 1: Multi-county and county/inter regional cooperation for the provision of prehospital care.

Objective 1: Monitor inter-county and county/inter-regional cooperation through Local Council relationships.

Strategy 1: Regional Council members or staff will attend Local Council meeting and invite dialogue regarding multi-county and county/inter-regional cooperation.

Projected Cost: $2500.00

Barriers: None identified

V. DESIGNATED TRAUMA CARE SERVICES

Designated Trauma Services

Issue/Need/Weakness Statement: There are two areas within the North Central Region where patient care will be enhanced by the elevated designation of trauma care services. These two areas are within Okanogan and Grant Counties.

Goal 1: Trauma Services are designated at the recommended number and levels in the North Central Region.

Objective 1: During the biennium, the Regional Council will continue to encourage and support the efforts of the trauma services that designated at lower levels to increase their designation levels, as they are able.

Strategy 1: Be available to the two facilities in Okanogan and Grant Counties to provide regional information and other support as requested.

Strategy 2: Be available to Mid-Valley Hospital to provide regional information and other support as they pursue Level Three designation.

Strategy 3: As requested, attend meetings; facilitate dialogue between the facilities and the Department of Health, Office of Emergency Medical and Trauma System.

Projected Cost: Unknown

Barriers: Healthcare facilities are unwilling to increase their level of designation

Hospital Disaster Preparedness

Issue/Need/Weakness Statement: With the current emphasis and importance of Bioterrorism Preparedness and Response, it is imperative that the Region works closely with the healthcare facilities within the region to prioritize the needs of those facilities and to assist them in further assessing the issues/needs/weaknesses in this area.

Goal 1: Disaster preparedness is collaborative between the Regional Council and the hospitals within the region.

Objective 1: During 2003, continue the dialogue already established with the region's healthcare facilities to identify the areas of greatest need, and to secure funding to assist in meeting those needs.

Strategy 1: Continue to facilitate meetings to bring the Healthcare Facilities Committee and the hospitals within the region for the purpose of the establishment of prioritizes and how best to use available funding resources.

Strategy 2: The Healthcare Facilities Committee will meet with all hospital representatives to develop a plan for determining the most pressing needs based on the recent bioterrorism hospital assessments and the Regional Bioterrorism Preparedness and Response Plan. Funding sources and the amount of funds available will be potential barrier.

Projected Cost: Unknown

Barriers: Lack of funding for this project

TABLE C

NORTH CENTRAL REGION

FY 04/05 Regional Plan

Min/Max Numbers for Acute Trauma Services

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
II	**1**	**1**	**1**	**1**	**1**
III	**2**	**2**	**0**	**2**	**2**
IV	**4**	**4**	**6**	**4**	**4**
V	**3**	**3**	**3**	**3**	**3**
IIP	**1**	**1**	**0**	**1**	**1**
IIIP	**1**	**2**	**1**	**1**	**2**

Min/Max Numbers for Rehabilitation Trauma Services

LEVEL	STATE APPROVED		CURRENT STATUS	REGION PROPOSED (Indicate changes with an *)	
	MIN	MAX		MIN	MAX
II	**1**	**1**	**1**	**1**	**1**
III+			**0**		

\+ *There are no restrictions on the number of Level III Rehab Services*

.

VI. DATA COLLECTION AND SUBMISSION

At this time, the Regional Council has not been active in the transition of prehospital to hospital trauma data submission.

Regional Council Role in Data Collection

Issue/Need/Weakness Statement: The Regional Council has not determined its role in the transition of prehospital data collection from agency submission to hospital submission.

Goal 1: The Regional Council's role in transitioning prehospital data is formalized.

Objective 1: The Regional QI Committee and the prehospital committee will address this issue and develop a recommendation to the council in FY 04.

Strategy 1: Discussion between the Regional QI Committee and the Prehospital Committee will begin by November 03 to develop a recommendation to present to the council.

Strategy 2: The Regional Council will take action on the recommendation by December 03.

Projected Cost: Unknown

Barriers: None identified

Prehospital Data

Issue/Need/Weakness Statement: We currently lack objective prehospital data to evaluate the effectiveness and weaknesses of the EMS and Trauma System.

Reasons for the weakness include;

1. Lack of a central data source from which data can be gathered and analyzed.
2. Multiple levels of dispatch, from local government to private agencies, making determination of response times more difficult.
3. Lack of personnel and funding to gather/analyze data.

Goal 1: **A**ll agencies in the region participate in data recording through their respective communication centers.

Objective 1: To have all EMS agencies fully participate in the recording of the dispatching of their respective units so as to provide a mechanism to collect response times. Where centralized dispatch currently exists, this should be accomplished immediately. Where centralized dispatch is in the development stages, upon start-up of operations (projected for July '04, those agencies should be fully participating.

***Strategy 1*:** The Regional Council will facilitate meetings between agencies and their respective communication centers to begin the coordinated effort to acquire data.

Projected Cost: Unknown **-** The cost of participating may be an issue, though 100% compliance is needed to effectively evaluate the system.

Barriers: Lack of funding and lack of cooperation and coordination between provider agencies and communication centers.

Incomplete Data Collection

Issue/Need/Weakness Statement: A number of the agencies, specifically the ALS Transport agencies that transport a significant percentage of trauma and medical patients to hospitals, use an agency specific medical incident report that they independently developed for their use. These medical incident reports only contain a part of the data elements needed in order for the hospitals to provide complete trauma data to the state for analysis. It is too time consuming for the hospitals to contact the EMS agencies afterward to obtain the missing data. The hospital will indicate "unknown" in these missing areas and submit incomplete data reports to the state.

Goal 1: A standardized EMS medical incident report form contains all of the data elements necessary for accurate and complete trauma system assessment.

Objective 1: Within the biennium, develop a standardized medical incident report form to be used by agencies that currently do not use the MIR form.

Strategy 1: Utilize the Prehospital Committee to draft a comprehensive medical incident report form that contains all necessary information, to include the trauma data elements required by the DOH OEMTP.
Strategy 2: Present the draft MIR to the Regional Council for approval and adoption.

Strategy 3: Print and distribute the approved MIR forms to all ALS agencies in the region.

Projected Cost: $10000.

Barriers: Lack of funding for this project

VII. EMS AND TRAUMA SYSTEM EVALUATION

Regional Quality Improvement

Issue/Need/Weakness: Central Washington Hospital is the site of the quarterly Regional QI Committee meetings. This committee has been meeting regularly. Until the last two years, the committee devoted all of its time to designated facility data review. Since that time, the EMS providers of the region have taken a more active role in the committee and this is expected to continue. The areas of discussion range from on scene transports, and inter-facility transports to appropriate trauma triage tool usage. Numerous provider agencies conduct their own in-house QA activities. The region has not surveyed those agencies to gather data on those activities. The region will be more aggressive in the coming year in an effort to gather appropriate data and be more active in the QA process throughout the region. The MPDs are taking a more active role in seeking QA information. This is an area where the Region expects to see much improvement.

Goal 1: An effective quality assurance program to determine areas of deficiencies.

Objective 1: Determine where systemic deficiencies exist and map a course to impact those deficiencies by the end of the biennium.

Strategy 1: Assign the responsibility of addressing this weakness to the regional prehospital committee.

Strategy 2: Develop and submit an updated prehospital component of the regional QA/QI plan that includes addressing the following:

a. Coordination of transporting agencies

b. Lack of objective prehospital data

c. Problems or restriction in obtaining intubations or IV access maintenance

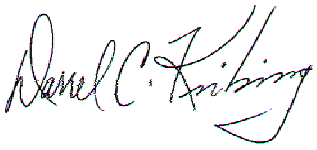
d. Tracking hospital diversion of prehospital ambulances

e. Communications capabilities for on-scene EMS to hospital direction

Strategy 3: Submit recommendations to the Regional QI Committee.

Projected Cost: Unknown

Barrier: Acquiring data that will accurately portray the system and its deficiencies.

Submitted by:  ***Date*** ***August 12, 2003***

APPENDIX I

DOH Criteria for Identifying Need & Distribution

Purpose:
Assure adequate availability and avoid inefficient duplication and lack of coordination of prehospital services within the region.

Regional Plan planning process shall include:
Regional EMS/TC councils identify the need for and recommend distribution and level of care (basic, intermediate or advanced life support) for verified aid and ambulance services for each response area identified in the plan.

WAC Criteria:
- Agency response times
- Geography
- Topography
- Population density.

Other WAC Requirements to be considered:
- Skill Maintenance

System influences to consider:
- Tiered Response
- Dispatch Procedures

Regional Analysis should consider agency response times:
- The ability of agencies to meet state verification response time standards as defined in WAC.

Regional Analysis could also consider:
- National standards for Cardiac response is 4 minutes for BLS and 8 minutes for ALS
- 8-minute response time in an urban system is acceptable and could be factored into determining the number of units a community will require.[1]
- In less populated or rural areas, longer response time may need to be accepted, "although Optimal response times are nonetheless Desirable." [1]

Geography and Topography:
- Distances between services and road mileage to incidents
- Proximity to Verified ILS or ALS services.
- Mountain, terrain and water barriers to the efficient response to parts of the populated areas.

Population & Population Density:
- National Data Studies
  - 1 ALS Agency per 40,000 population
  - 1 emergency transport per day per 7,000 – 10,000 population[1&2]
  - Emergency transports per year = 3.5% of population[1&2]
  - 20 – 30% of all 911 calls will require paramedic skills[3]

- Tourism influence[2]
- 65+ Population[2]
- Economic Variables of the population[2]
- *Example:* A community in the 25th percentile of median income would be expected to experience 103 more responses than a community of similar size in the 75th percentile of median income.

Skill Maintenance:

- WAC Requirement -

Initial Certification Period	Recertification
IVs – 36 per year	Demonstrated Proficiency
ETs – 12 per year	4 per year

- National Recommendations -
  - ACEP – 2.4 to 8.9 ETs per year. [4]

Region must consider:

- Can IV skill maintenance be achieved within the prehospital responses?
- Can ET skill maintenance be met within the community or will other opportunities for personnel to maintain skills be required?

Other Impacts to be addressed:

- Tiered Response
  - Article review finds most recommendations are for a 2 or 3 tiered response
  - Does the Region have a PCP for Tiered Response and/or Rendezvous?
- Dispatch Protocols:
  - National Recommendations for dispatch:
    - Single separate entity not associated with providers
    - Priority Dispatch Protocols and System Status Management[3]
    - Optimal Deployment Management[5]

REFERENCES

1 Roush, William, MD: *Principles of EMS Systems*

2 Cadigan, Robert T., PhD, Burgarin, Carol E. MD: Predicting Demand for Emergency Ambulance Service, *Annals of Emergency Medicine, June 6, 1989*

3 Cadigan, Robert T., PhD, Burgarin, Carol E. MD: Predicting Demand for Emergency Ambulance Service, *Annals of Emergency Medicine, June 6, 1989*

4 O'Connor, MD, Clarke, et.al: Endotracheal Intubations Field Experience: Is there a minimum Amount Required for Paramedics to Maintain Proficiency? *National Association of Emergency Medical Services Physicians, June 1995.*

5 Fitch, J.J. PhD: *EMS Management Beyond the Street, 1993*

APPENDIX II

IDENTIFYING NEED & DISTRIBUTION – GRANT COUNTY

Based on the recommendation of the Grant County EMS & Trauma Care Council and the below provided information, the North Central Regional Council recommends for DOH approval the changes in the Amb-ALS minimum and maximum increasing the numbers by one (1). Due in part to the increased population and proximity of ALS transport services to those populated areas the recommendation is forwarded to the Department of Health. The effect on response areas is noted in the Need & Distribution chart. Another contributing factor is the operation of the ILS agency currently licensed and verified in the affected area. Though this entity exists on paper, it is the Region's understanding that it does not in actuality respond. The goal of the Regional Council in recommending an ILS verification in the affected area at the last planning cycle was to add response bases closer to the more populated areas in Grant County Fire Dist. #5 jurisdiction, to increase the number of units available to respond. With the current contractual arrangement, these two goals have not been met.

Below is the justification for increasing the min/max for verified ALS services in Grant Count as required, according to WAC 246-976-960, Criteria for Identifying Need & Distribution (Attachment I).

Weaknesses: In the North Central Region 2002-03 Plan, page 46, the following weakness was identified:

> *"Within the central part of Grant County, the area that encompasses the geo-political boundaries of Grant County FD #5, #4 and the Port of Moses Lake, it has been identified that an ALS service is necessary to provide response to a growing population base. The Grant County EMS & Trauma Care Council has recommended and the North Central Regional Council recommends an increase in ALS transport verification maximums for this area. The added ALS transport verification should serve Grant Co. FD #5 and #4 proper . . ."*

Also, the North Central Region identified distances between EMS providers and incident locations, page 47:

> *"Throughout the region, there are long distances between EMS providers and incident locations. Though it is impossible to alleviate all long responses to these rural areas, the regional council will be looking for ways to shorten them where possible."*

With these weaknesses being identified, the Grant County EMS & Trauma Care Council is addressing the required criteria to demonstrate the need for an increase in the ALS transport verification maximums in the North Central Region 2004-05 plan.

WAC Criteria:
The following areas, according to WAC 246-976-960, should be considered when identifying need:

1. **Agency Response Times:**

   In considering agency response times, we evaluated response times of both Grant County FD 5 and Moses Lake Fire Department to several areas within the proposed new ALS response area. This included all of Grant County FD 4, 5 and the Port of Moses Lake and a portion of Grant County FD 15.[6]

   In the evaluation we used the recommendations of the DOH concerning National Standards for response of ALS. During the evaluation, we discovered a deficiency in meeting the recommended 8-minute response for ALS. With the addition of the ALS agency, we can meet the 8-minute standard, even in areas less populated or considered rural.[1, 6]

   The national standard for Cardiac response is 4 minutes for BLS and 8 minutes for ALS.[1] American Heart Association documents that brain death and permanent death start to occur in just 4 to 6 minutes after someone experiences cardiac arrest. A victim's chances of survival are reduced by 7 to 10 percent with every minute that passes without defibrillation.[2]

   In Fire District 5, we have reduced the response time of ALS arriving on-scene to critical cardiac and trauma events from 10 minutes to 8 minutes.[6]

   In Fire District 4, we have reduced the response time of ALS arriving on-scene to critical cardiac and trauma events from 20 minutes to 14 minutes.[6]

   Both agencies are currently able to meet the WAC Standards for verified response of 20-minutes for Suburban and 45-minutes for Rural areas, "although Optimal response times are nonetheless Desirable."[1]

   Response time data is contained in Attachment II – Analysis of Agency Response Times.[6]

2. **Geography and Topography:**
   The land area of Grant County is 2,676.4 square miles.[4,5] Grant County Fire District 5 serves over 700 square miles of the county either by jurisdictional authority or by contract. A twenty-five mile stretch of Interstate 90 runs through Grant County Fire Districts 4, 5 and 15 and twenty-three miles of State Route 17, two of the most highly traveled roads in the region.

   Numerous industries utilize the Port of Moses Lake and other areas of Grant County Fire Districts 4 and 5 not only as production sites but transportation and distribution hubs.

   The Grant County International Airport serves as a training center for Japan Airlines and test site for Boeing. There is daily passenger carrying flights in and out of the airport.

   The 704 square miles that make up Grant County Fire District 4, 5 and 15 is used primarily for farming and agriculture. Each year the Fire Districts experience injuries and loss of life due to farm related activities.

The irrigated farmlands have provided food, cover and the necessary water to give the area a large waterfowl population. Waterfowl populations reach peaks of over 100,000 birds during the fall season attracting hunters into the Fire Districts.

The Sand Dunes area (one of the largest in the region) is located with in Grant County Fire District 5. Primarily ATV visitors and local citizens use the Sand Dunes and can draw as many as 4,000 people on some holiday weekends, during which numerous trauma and medical calls requiring transport. Areas within the Sand Dunes can only be accessed with all terrain vehicles, which Fire District 5 maintains with emergency medical equipment for this purpose.

The over 247,000 surface acres of water in or near these Fire Districts draw fisherman year round and water craft enthusiasts throughout the summer months. The shear water mass and access to many of the remote lakes requires specialized vehicles, which Grant County Fire District 5 and Moses Lake Fire Department have readily available.

3. **Population & Population Density:**

Population data for Washington State is available from two primary sources. Those sources are the U.S. Census Bureau, United States Department of Commerce and the Office of Financial Management, State of Washington.

The report used for the population and demographics data for Grant County is complied from the two above by the Grant County Health District.

Population Statistics for Grant County[4, 5]

	1990 Census	2000 Census	Percent of Change
Total Population	54,798	74,698	36.3% ↑
Incorporated	28,392	38,901	37.0% ↑
Un-incorporated	26,406	35,797	35.6% ↑

Approximately half (52%) of Grant County's population live within an incorporated area in 1990 and 2000. The remainder (48%) of the population live in unincorporated area of the county.

The current population census in Grant County Fire District 5 is 16,828. This classifies the Fire District as a suburban area.[3]

The current population census in Grant County Fire District 4 is 4,000. This classifies Fire District 4 as a rural area.[3]

Population by Census Designated Place (CDP)[4, 5]

Census Designated Places (CDP) are closely settled, named, unincorporated communities that generally contain a mixture of residential, commercial and retail areas similar to those found in incorporated places of similar size. In Census 2000, data was gathered for five CDP's, two in Fire District #5 were designated.

CDP Area	1990 Census	2000 Census	Protecting Jurisdiction	Percent Change
Cascade Valley	1288	1811	Grant County FD#5	40.6% ↑
Moses Lake North	3677	4232	Grant County FD#5	15.1% ↑

These CDP prove useful for seeing the increase of population in unincorporated areas. The Cascade Valley area has seen a large influx of construction of residential homes that has continued into this planning period. The increases in these areas are having impacts on emergency medical responses for the associated agencies. We are tracking the increases in population and responses into this planning period to determine impact on the responsible agencies.

National Data Studies for Call Volume:

National data studies as developed by information from the DOH-OEMTP office provide several avenues for analyzing call volume data in relation to population densities. We have chosen to review based upon actual data as provided through the Fire District data collection system and the Multi-Agency Communications Center. [6]

In the year 2002 there was a 20.9 percent difference in call volume based on population comparisons to actual calls in Fire District No. 4 & 5. The following table demonstrates actual call volumes in comparison to nationally accepted methods for computing call volumes in the absence of good community data on demand.[1 & 2] Data demonstrates that there is a greater number of utilizations of emergency medical services than can be predicted by using a formula. [6]

Year	Actual Call Volume	Predicted by Formula 3.5% of Population	Percentage of Difference
2002	922*	729	20.9% ↑

* Data only includes 7 months of transport response data in Fire District 5, and total responses in Fire District 4.

Tourism Influences:

As described in the Geography and Topography section of this report, there is a significant tourism influence in Fire Districts 4 & 5. Throughout the months of March to October the two Fire Districts see increases in population of up to 30 percent. During certain holiday weekends and special events, the population increases by almost 40 percent.

The increase in population causes significant impact on the emergency medical system, at times tasking it to the point of requiring mutual aid assets from the Ephrata and Royal City areas.

Other WAC Requirements to be considered: [6]

1. **Skill Maintenance**. Grant County Fire District No. 5 is currently pursuing contracts with facilities, not only in the Moses Lake area, but also in surrounding communities, to facilitate Endotracheal (ET) and Intravenous Therapy skill maintenance requirements as defined in WAC 246-976-161.

   The Fire District provides all Intermediate or Paramedic Personnel with training opportunities to meet the required IV and ET skill requirements. This is accomplished by providing clinical opportunities at Central Washington Hospital in Wenatchee, WA and Kadelac Medical Center in Richland, WA as well as the Grant County Coroner's Office in Moses Lake, WA.

2. **First Certification Period**. All personnel are provided with both field and clinical opportunities to meet the skill requirements as set forth in WAC for the First Certification Period. (108 IVs/36 Intubations).

3. **Later Certification Period**. All personnel are provided with both field and clinical opportunities to meet the skill requirements to re-certify for later Certification Periods. Accurate field and clinical data for number of skills available is not yet available for Fire Districts 4 & 5; to date (November 2002 to March 23, 2003) there have been 183 IV's successfully started and 11 field and 8 clinical successful ET tubes placed. [6]

System Influences:

1. **Tiered Response**.

Currently, the Grant County EMS & Trauma Care Council COP #1 – Tiered Response Rendezvous is not being fully utilized within Fire Districts 4, 5, 12 & 15.

Grant County Fire District No. 5 will continue to provide a tiered response system with surrounding agencies and within the Fire District. Within Fire Districts 5 and 15, a BLS non-transport first response is provided by one of twelve stations followed by an ALS transport response from two ALS stations located within Fire District 5. Portions of Fire District 15 are provided both a BLS transport response from Grant County Fire District 10 and an ALS transport response from Ephrata Ambulance.

Fire District 4 provides BLS non-transport first response followed by contracted ALS transport services from Fire District 5. The system has seen a reduction in response times as indicated in previous sections. [6]

Fire District 5 currently supports tiered response with other agencies, such as Ephrata Ambulance and Grant County Fire District 10 Ambulance.

There are currently issues with the delivery of tiered response within the Fire District 4 & 5 as the current ILS Tier is not supported. [6] With the addition of the new ALS response area, more efficient tiered response will be supported.

2. **Dispatch Procedures**.

Dispatch procedures within the new ALS response area will follow the standards in place by North Central Region EMS & Trauma Care Council Patient Care Procedure – Dispatch of Agencies.

Within the new ALS response area, dispatching will provide a two-tiered response system with a BLS non-transport first response tier and an ALS transport tier. This provides the fastest access to the system and early defibrillation and gives patients an earlier access time to ALS level of care. [6]

REFERENCES

1 Rousch, William, MD: *Principles of EMS Systems*
2 American Heart Association: *Heart Disease and Stroke Statistics – 2003 Update*
3 WAC 246-976-010 Definitions
4 Grant County Trauma Care Plan Recommendations FY2004-05
5 Grant County Health District: *A Description of Grant County: Population, August 2001*
6 Data and information provided by Grant County Fire District No. 5

Analysis of Agency Response Times

Zone	Number of Calls	GCFD 5 Average	MLFD Average	Average Response	Time Difference
410	**20**	**13:35**		**19:22**	**5:47**
420	**26**	**14:46**		**20:09**	**5:23**
518	**26**	**6:19**		**6:22**	**0:03**
521	**13**	**8:48**		**8:06**	**0:42***
548	**11**	**8:09**		**9:08**	**0:59**
584	**92**	**3:49**		**7:01**	**3:12**
589	**1**	**4:46**		**4:54**	**0:08**
595	**1**	**4:44**		**5:49**	**1:05**
5111	**4**	**10:31**		**11:59**	**1:28**
5108A	**1**	**6:55**		**9:32**	**2:37**
5111A	**2**	**7:04**		**14:35**	**7:31**
511B	**1**	**4:59**		**8:26**	**3:27**
515A	**10**	**6:37**		**9:40**	**3:03**
535A	**1**	**10:30**		**12:03**	**1:33**
551A	**12**	**7:33**		**8:52**	**1:19**
551B	**5**	**5:06**		**6:19**	**1:13**
569A	**5**	**11:44**		**15:05**	**3:21**
572C	**1**	**15:54**		**13:00**	**2:54***
PORT	**2**	**5:06**		**7:37**	**2:31**

***Moses Lake Fire Department arrived on scene first when calculating average times.**

Data obtained from the Multi Agency Communication Center (MACC). Removed calls where one of the agencies did not check in route and/or on scene according to MACC. Also removed calls where no Zone was input by dispatchers.

Response Time – is the time from agency notification until the time the first EMS Personnel arrive at the scene from each agency.

APPENDIX III

North Central Region EMS & Trauma Care Council | ***Patient Care Procedure*** **Dispatch of Agencies**

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE

1. To provide timely & appropriate care to all emergency medical & trauma patients as identified in WAC 246-976-390.
2. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
3. To establish uniform & appropriate dispatch of response agencies.
4. To utilize Criteria Based EMD trained dispatchers to identify potential Major Trauma incidents & activate the Trauma System by dispatching the appropriate services.

II. STANDARDS:

1. Licensed aid and/or licensed ambulance services shall be dispatched by trained dispatchers to all emergency medical incidents.
2. Verified aid and/or verified ambulance services shall be dispatched by trained dispatchers to all known injury incidents, which meet Trauma Registry Inclusion Criteria.
3. All Communication/Dispatch Centers charged with the responsibility of receiving calls for Emergency Medical Services shall develop or adopt an EMD (Emergency Medical Dispatch) Program that meets the Washington EMD Program and Implementation Guidelines.

III. PROCEDURE:

1. The nearest appropriate aid and/or ambulance service shall be dispatched per the above standards as identified in the North Central Regional EMS/Trauma Care response area maps, or as defined in local and/or county operating procedures.

IV. DEFINITION:

1. Per WAC 246-976-010, "response time" is defined as "the time from agency notification until the time the first EMS personnel arrive at the scene."
2. "Appropriate" is defined as "the verified or licensed service that normally responds within an identified service area."

V. QUALITY IMPROVEMENT

The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE

1. To define prehospital response times for emergency medical & trauma incidents to urban, suburban, rural and wilderness areas in the North Central Region.
2. To define urban, suburban, rural and wilderness response areas.
3. To provide trauma patients with appropriate & timely care.

II. STANDARDS:

1. All verified ambulance & aid services shall respond to emergency medical & trauma incidents in a timely manner in accordance with WAC 246-976-390.
2. All licensed ambulance & aid services shall respond to emergency medical incidents in a timely manner.

III. PROCEDURE:

1. The Regional Council, with input from prehospital providers and Local Councils, shall identify response areas & times as urban, suburban, rural and wilderness.
2. Verified/licensed ambulance & verified/licensed aid services shall collect & submit documentation to ensure the following response times are met or exceeded as established by PCP, COP or WAC 246-976-390 & 430.

Aid Vehicle		Ambulance	
Urban	8 minutes	Urban	10 minutes
Suburban	15 minutes	Suburban	20 minutes
Rural	45 minutes	Rural	45 minutes
Wilderness	ASAP	Wilderness	ASAP

3. Verified aid & ambulance services shall provide documentation on major trauma cases to show the above response times are met 80% of the time.
4. County Operating Procedures must meet or exceed the above standards.
5. Verified/licensed ambulance & verified/licensed aid are encouraged to set the "Golden Hour" as a goal for wilderness response times.

IV. DEFINITION:

1. An agency response area or portion thereof:
   a. **Urban** - an incorporated area over 30,000; or an incorporated or unincorporated area of at least 10,000 & a population density over 2,000 per square mile.
   b. **Suburban** – an incorporated or unincorporated area with a population of 10,000 to 29,999, or any area with a population density of 1,000 to 2,000 per square mile.

c. **Rural** - an incorporated or unincorporated area with total populations less than 10,000 or with a population density of less than 1,000 per square mile.

d. **Wilderness** - any rural area not readily accessible by public or private road.

2. **Agency response time** is defined as the time from agency notification until the time the first EMS personnel arrive at the scene. (This is defined in WAC and constitutes "activation time" plus "enroute time.")

V. QUALITY IMPROVEMENT:

1. The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

North Central Region EMS &
Trauma Care Council

Patient Care Procedure

Timely & Appropriate EMS Response

Adopted by Regional Council: 04/04/01
Approved by DOH: 04/01/02
Revised:

I. PURPOSE

1. To ensure that emergency medical & trauma patients who live in an area that is serviced by two or more ambulance providers, which have the same level of licensure, receive the timeliest & highest level of care that is available.

II. STANDARDS:

1. If available, the highest-level "appropriately staffed" ambulance within a designated area shall be dispatched to emergency medical & trauma incidents.

III. PROCEDURE:

1. Except when "extraordinary circumstances" exist, the highest level "appropriately staffed" licensed ambulance shall respond to all emergency medical & trauma incidents.
2. When a licensed ambulance provider is unable to immediately respond an "appropriately staffed" ambulance to an emergency medical or trauma incident, and there exists another ambulance which is "appropriately staffed" and capable of responding to the incident in a timely manner, then the service that was originally dispatched shall transfer the call to the second ambulance for response.
3. This procedure shall only apply to emergency calls received through the county 911-dispatch center.

IV. DEFINITION:

1. **Extraordinary Circumstances** shall be defined as situations out of the usual when all available ambulances from local licensed ambulance providers are committed to calls for service.
2. **Appropriately Staffed** shall be defined as an ambulance which immediately initiates it's response to an emergency medical or trauma incident staffed with at least two crew members which are certified to a level that is commensurate with the standard of care that has been set in the local area. (i.e., Paramedic/EMT, ILS-EMT/EMT, EMT/EMT or EMT/1st Responder)
3. **Highest Level** shall be defined as the service within the response area that has the highest level of certified personnel available, at the time of the call.

V. QUALITY IMPROVEMENT:

1. The Regional Quality Improvement Program shall develop a written plan for implementation to address issues of compliance with the above standards & procedures.

Adopted by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

I. PURPOSE:

1. To define who may initiate the request for on-scene emergency air medical services, and under what circumstances non-medical personnel may request on-scene air medical services.
2. To institute a program of continuous evaluation to determine the best utilization of air medical services in our region.

II. STANDARDS:

1. Early activation of air ambulance services should be initiated as soon as the medical condition of the patient and scene location/conditions would favor, by at least 10 minutes, air transport of the major trauma or critical medical patient.

III. PROCEDURE:

1. Air ambulance services should be used when it will reduce total out of hospital time for a major trauma patient by 10 minutes or more.
2. Air ambulance services may be used for medical and non-major trauma patients under special circumstance and only with clearance by medical control.
3. Prehospital personnel en route to the scene should make the request to place an air ambulance service on standby, or initiate a request for an on-scene response.
4. The call must be initiated through the appropriate medical emergency dispatching agency.
5. The helicopter communications staff will always give an approximate launch time, flight time and advise when lifted to the dispatchers requesting services.
6. The responding helicopter will make radio contact with the receiving hospital at, or shortly after liftoff from the scene.
7. An air ambulance that has been launched or placed on standby can only be cancelled by the highest level of transporting prehospital personnel dispatched to the scene.

IV. DEFINITION:

1. **Standby:** Upon receiving the request, dispatch will notify the pilot and crew of the possible flight. The crew will respond to the aircraft and ensure they are in a flight ready status. The crew will then remain at or near the aircraft until such time as they are launched or released from the standby.
2. **Launch Time:** Launch time is the time the skids lift the helipad en route to the scene location.

V. QUALITY IMPROVEMENT:

1. A regional helicopter response report form for each flight or standby request, including cancelled flights, must be submitted to the QI Committee at the end of each calendar quarter. These will be reviewed, with local input, to develop a definition of the most appropriate circumstances for helicopter requests.

North Central Region EMS & Trauma Care Council

Patient Care Procedure
IDENTIFICATION OF MAJOR TRAUMA & EMERGENCY MEDICAL PATIENTS

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To implement regional policies and procedures for all emergency medical patients and all trauma patients who meet the criteria for trauma system activation as described in the Washington Prehospital Trauma Triage Procedures.

2. To ensure that all emergency medical patients are transported to the closest most appropriate facility in the shortest time possible.

3. To ensure that all major trauma patients are transported to the most appropriate facility capable of meeting the patient's need in accordance with WAC 246-976-370.

4. To allow the designated facility sufficient time to activate their emergency medical and/or trauma resuscitation team. (See WAC 246-976-550 (d).

II. STANDARDS:

1. Major trauma patients will be identified in the initial EMS field assessment using the most current State of Washington Prehospital Trauma Triage (Destination) Procedures as published by the Department of Health.

2. Major trauma patients will be identified by the region's prehospital services and hospitals for the purposes of state trauma registry inclusion using the trauma registry inclusion criteria as outlined in WAC 246-976-430.

3. Major trauma patients will be identified for the purposes of regional quality improvement as patients who meet the Trauma System Activation criteria of the most current version of the State of Washington Prehospital Triage Procedures, and patients who activate hospital resource teams and those who meet the hospital trauma patient registry criteria.

4. Patients not meeting the criteria to activate the trauma system will be transported to the closest most appropriate local facility as outlined in local procedures.

III. PROCEDURE:

1. The first certified EMS/TC provider to determine that a patient:
   a. Meets the trauma triage criteria and/or
   b. Presents with factors suggesting potential severe injury (in accordance with the Washington Prehospital Triage Procedure)
   c. Needs definitive medical care should contact the nearest appropriate highest designated facility via the H.E.A.R. frequency (or other means as conditions dictate).

2. Radio contact with the receiving facility should be preceded with the phrase: "This is a major trauma or major heart alert."

3. The receiving facility shall be provided with the following information, as outlined in the Prehospital Destination Tool:

   a. Identification of EMS agency.
   b. Patient's age.
   c. Patient's chief complaint or problem.
   d. If injury, identification of the biomechanics and anatomy of the injury.
   e. Vital signs.
   f. Level of consciousness.
   g. Other factors that require consultation with medical control.
   h. Number of patients (if more than one).
   i. Amount of time it would take to transport the patient from scene to the nearest appropriate hospital (transport time).

4. When determined that a patient meets the trauma triage criteria, a Washington State Trauma Registry Band should be attached to the patient's wrist or ankle as soon as appropriate.

5. Whenever possible, ILS or ALS service should be dispatched to the scene by ground or air as appropriate. <u>If unavailable, rendezvous will be arranged with the highest possible level of care.</u>

6. While enroute to the receiving facility, the transporting agency shall provide complete report to the receiving hospital regarding the patient's status.

7. All information shall be documented on an appropriate medical incident report (MIR) form approved by the county medical program director.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To ensure that trauma patients receive treatment in facilities that have made a commitment to the provision of designated trauma service.

2. To define the referral resources for inter-facility transfers of patients requiring a higher level of care or transfer due to situational inability to provide care.

3. To recommend criteria for inter-facility transfer of major trauma patients from receiving facility to a higher level of care.

II. STANDARDS:

1. Written transfer agreements will be in place among all facilities in the region and tertiary care facilities commonly referred to which are out of the region.

2. All interfacility transfers shall be in compliance with current OBRA/COBRA regulations and consistent with RCW 70.170.060(02).

3. Level IV and V facilities will transfer the following adult and pediatric patients to level I or II facilities for post resuscitation care:

Central Nervous System Injury Dx
Head injury with any one of the following:
- Open, penetrating, or depressed skull fracture
- Severe coma (Glasgow Coma Score <10)
- Deterioration in Coma Score of 2 or more points
- Lateralizing signs

Unstable spine
Spinal cord injury (any level)
Chest Injury Dx
Suspected great vessel or cardiac injuries
Major chest wall injury
Patients who may require protracted ventilation
Pelvis Injury Dx
Pelvic ring disruption with shock requiring more than 5 units of blood transfusion
Evidence of continued hemorrhage
Compounded/open pelvic fracture or pelvic visceral injury
Multiple System Injury Dx

Severe facial injury with head injury
Chest injury with head injury
Abdominal or pelvic injury with head injury
Burns with head injury

Specialized Problems
Burns > 20% BSA or involving airway
Carbon monoxide poisoning
Barotrauma

Secondary Deterioration (Late Sequelae)
Patients requiring mechanical ventilation
Sepsis
Organ system(s) failure (deterioration in CNS, cardiac, pulmonary, hepatic, renal, or coagulation systems)

4. All pediatric patients less than 15 years who are triaged under Step I or II of the Prehospital triage tool, or are unstable after ED resuscitation or emergent observation intervention at hospital with general designations should be considered for immediate transfer to a level I designated pediatric trauma center.

5. For inter-facility transfer of critical major trauma patients, air or ground ALS transport is the standard. Trauma verified services shall be used for all inter-facility transfers of major trauma patients.

6. Transport of patients out of region shall be consistent with these standards.

III. PROCEDURE:

1. The General and Pediatric Trauma Transfer Criteria established by the Department of Health should be followed. Each designated trauma facility is required to develop procedures, protocols, and criteria defining which patients they keep or transfer.

2. The transferring facility must make arrangements for the appropriate level of care during transport.

3. The receiving facility must accept the transfer prior to the patient leaving the sending facility.

4. The receiving physician must accept the transfer prior to the patient leaving the sending facility.

5. All appropriate documentation must accompany the patient to the receiving facility.

6. The transferring physician's order shall be followed during transport as allowed by MPD protocols. Should the patient's condition change during transport, the transferring/sending physician, if readily available, should be contacted for further orders.

7. The receiving facility will be given the following information:
    a. Brief history

b. Pertinent physical findings
c. Summary of treatment
d. Response to therapy and current condition

8. Further orders to transport personnel may be given by the receiving physician.

9. MPD approved Prehospital Protocols will be followed during transport, unless direct medical orders are given to the contrary.

10. Level IV and V trauma facilities should consider having trauma patients transferred by either ground or air according to the facility's interfacility transport plan.

11. Air transport should be considered for interfacility transfer in the North Central Region when transport by ground will be greater than 30 minutes.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

North Central Region EMS &
Trauma Care Council

Patient Care Procedure
DESIGNATED TRAUMA CENTER DIVERSION

Adopted by Regional Council:	10/23/1998
Approved by DOH:	10/23/1998
Revised:	

I. PURPOSE

1. To define implications for initiation of trauma center diversion (bypass) status in the Region.
2. To define the methods for notification of initiation of trauma center diversion.
3. To identify situations when a facility must consider diverting major trauma patients to another designated trauma center.

II. STANDARDS:

1. Designated trauma centers in the North Central Region will go on diversion for receiving major trauma patients based on the facilities' ability to provide initial resuscitation, diagnostic procedures, and operative intervention at the designated level of care.

2. Diversion will be categorized as partial or total based on the inability of the facility to manage specific types of major trauma or all major traumas at the time.

   Hospitals must consider diversion when:
   - Surgeon is unavailable
   - OR is unavailable
   - CT is down if Level II
   - ER unable to manage more major trauma
   - Beds are unavailable
   - Shortage of needed staff

3. Each designated trauma center will have a hospital approved policy to divert patient to other designated facilities on the ability to manage each patient at a particular time. A diversion log will be kept indicating the time of diversion and the reason for partial or total diversion.

4. All facilities initiating diversion must provide notification to other designated trauma centers in Region.

III. PROCEDURE:

1. Trauma centers will consider diverting major trauma patients based on the above standards.

2. A designated trauma center on partial or total diversion shall notify other designated trauma centers in the Region.

IV. QUALITY IMPROVEMENT

The regional quality improvement program shall develop a written plan for implementation to address issues of compliance with the above standards and procedures.

APPENDIX IV

Grant County EMS &
Trauma Care Council

County Operating Procedures
Procedure #1-Tiered Response Rendezvous

Adopted by Grant County Council:
Recommended by Regional Council: 04/04/2001
Approved by DOH: 02/13/2002
Revised:

Purpose:

The Grant County Local Council encourages tiered response within the county. A tiered response system shall be used to provide an appropriate higher level of care anywhere in Grant County such care is readily available. Recognizing that there are areas where a tiered response is not appropriate because of time and distance, a rendezvous with an appropriate higher level of care will be requested, per Grant County EMS Protocols, anywhere in Grant County such a rendezvous is readily available.

Procedure for Tiered Response:

1. The nearest appropriately trained personnel and/or agency shall be dispatched as the primary ambulance.
2. If the severity of the incident is known and indicates the necessity of higher level of care, the dispatchers should also dispatch the next level of care immediately in those areas where the Grant County Local Council has identified a tiered response.
3. If the severity of the incident is unknown, the primary ambulance shall advise dispatchers to dispatch the next level of care as outlined in the Grant County Protocols. The primary ambulance will not delay transport to wait for the higher level of care, but will rendezvous instead.
4. When both agencies are on scene, the higher level personnel will assume care of the patient, and determine which ambulance transports.

Procedure for Rendezvous:

1. In areas where no tiered response has been identified, agencies should request a rendezvous with a higher level of care as outlined in the Grant County Protocols, if such care is readily available.
2. No agency, including ILS and ALS agencies, should delay transport of any patient to perform advanced skills that can be performed en route to the hospital.
3. When two agencies rendezvous, the higher level of care shall board the primary ambulance and assume responsibility for the care of the patient.

Quality Assurance:

The Grant County Quality Assurance Committee will analyze and make necessary changes in this procedure as may be indicated.

Adopted by Greater Wenatchee Council: May 15, 1996
Recommended by Regional Council: 1996
Approved by DOH: 1996
Revised:

Purpose:

1. To define the situations in which Advanced Life Support (ALS) agencies will be dispatched to emergency medical and major trauma incidents on U.S. 97 in Douglas County in the area between Sun Cove Estates and Twin W Orchards (milepost 224 to milepost 27).
2. To provide timely and appropriate care to all emergency medical and trauma patients.
3. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
4. To establish uniformity and appropriate dispatch of ALS response agencies.

Standard:

1. An ALS agency from Chelan shall be automatically dispatched to all known emergency medical and major trauma incidents on the above-mentioned stretch of U.S. 97 in Douglas County.
2. All major trauma patients on this stretch of U.S. 97 shall be automatically transported to highest-level designated trauma center.
3. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate.

Procedure:

1. Waterville Ambulance shall be dispatched to all major trauma incidents on U. S. 97 to milepost 227. If ALS (paramedic) certified personnel are part of the response team, the dispatch center shall be so notified.
2. When the location of the emergency medical or major trauma incident is south of milepost 224 (entrance to Sun Cove Estates), an ALS agency out of Wenatchee shall be automatically dispatched to the scene.
3. When the location of the emergency medical or major trauma incident is north of milepost 224, the ALS agency out of Chelan shall be automatically dispatched to the scene.
4. All major trauma patients shall be transported to Central Washington Hospital in Wenatchee if within 30 minutes transport time. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.
5. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate. If the patient has a life threatening condition, the patient should be taken to the closest appropriate facility per regional patient care procedures.

Quality Improvement:

The Regional Quality Improvement Committee shall develop written plan for implementation to address issues of compliance with the above standards and procedures.

Adopted by Greater Wenatchee County Council: May 15, 1996
Recommended by Regional Council: 1996
Approved by DOH: 1996
Revised:

Purpose:

1. To define the situations in which Advanced Life Support (ALS) agencies will be dispatched to emergency medical and major trauma incidents in the Douglas County Fire District #4 service area currently served by Waterville Ambulance (milepost 138 to milepost 142.5 on U.S. 2, and milepost 213 north to milepost 224 on U.S. 97.
2. To provide timely and appropriate care to all emergency medical and trauma patients
3. To minimize "response time" in order to get appropriately trained EMS personnel to the scene as quickly as possible.
4. To establish uniformity and appropriate dispatch of ALS response agencies.

Standard:

1. An ALS agency from Wenatchee shall be automatically dispatched to all known emergency medical and major trauma incidents on the above-mentioned areas in Douglas County.
2. All major trauma patients on the above-mentioned areas of Douglas County shall be automatically transported to highest-level designated trauma center.
3. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate.

Procedure:

1. Waterville Ambulance shall be dispatched to all major trauma incidents in the above-mentioned area. If ALS (paramedic) certified personnel are part of the response team, the dispatch center shall be so notified.
2. An ALS agency out of Wenatchee shall automatically be dispatched to all emergency medical and major trauma incidents in the above-mentioned area.
3. All major trauma patients shall be transported to Central Washington Hospital in Wenatchee if within 30 minutes transport time. In areas where a designated trauma facility is beyond 30 minutes transport time by air or ground, the patient will be taken to the closest appropriate medical facility for stabilization and then transferred to an appropriate designated trauma facility.
4. Emergency medical patients shall be transported to the facility of the patient's choice, if medically appropriate. If the patient has a life threatening condition, the patient should be taken to the closest appropriate facility per regional patient care procedures.

Quality Improvement:

The Regional Quality Improvement Committee shall develop written plan for implementation to address issues of compliance with the above standards and procedures.